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Fish oil in cancer cachexia

I note that the article by Kreijkamp-Kaspers et al on fish oil (*AFP* July 2015)¹ did not mention fish oil in the setting of cancer cachexia, which has a large literature base.

Recent work that has incorporated red cell membrane levels, to assess adherence and absorption, has again raised interest in the therapeutic value of fish oil in cancer cachexia combined with other modalities such as exercise, nutritional support and pharmacological agents.² Given the quality-of-life impact and high prevalence of this condition, its use in this context may warrant a mention.

References

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Reply

We thank Dr Martin for his letter regarding the role of fish oil in the setting of cancer cachexia. In our article we focused on the questions that patients and healthcare professionals asked through a medicines call centre¹ about fish oil; the role of fish oil in cancer cachexia was not a major theme.

Despite the large literature base looking at fish oil in cachexia the evidence is still inconclusive and the most recent review has concluded that 'There is not enough evidence to support a net benefit of n-3-FA in cachexia in advanced cancer'.²

On behalf of the authors,

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Consequences of obstructive sleep apnoea in childhood

I read with interest the article 'Sleep apnoea in the child' by Nixon et al (*AFP* June 2015).¹ There are two aspects that are worth considering. First, children with obstructive sleep apnoea (OSA) have a reduced exercise capacity (independent of their body mass index) and a higher risk for pedestrian injury when compared with healthy controls.^{2–3} Second, children with OSA appear to eat more calorie-dense foods, such as fast food, and less high-fibre foods, such as vegetables, fruits and whole grains.^{4–5} I think that as an additional part of OSA treatment in childhood, healthy eating practices should be implemented.

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Reply

Dr Hofmeister points out literature pertaining to associations between OSA in childhood, exercise capacity, pedestrian injury and dietary choices. We agree that management of a child with OSA should always include discussion of diet and exercise, and management of obesity if present. Evidence (including the papers referenced) would suggest, however, that consumption of high-calorie foods may be a consequence of sleep disturbance rather than (or as well as) a cause of obesity and thus OSA. Inadequate sleep and OSA can alter the balance between the appetite-related hormones leptin and ghrelin, resulting in an increased drive to eat high-calorie foods. The interactions between OSA, obesity, appetite and exercise are fascinating and complex, and this web of interactions may influence an individual family's ability to follow dietary advice; however this should not detract from the direct management of OSA initially.

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Urgent information on peanut allergy: New evidence from the LEAP study

In 2012 *AFP* published our letter, which discussed the increase in food allergies in Australian children in the past two decades.¹ We highlighted recent research at that time, suggesting decreased rates of peanut and egg allergy as a consequence of introducing these allergens from 4 months of age.^{2,3}

In February 2015, the Learning Early about Peanut Allergy trial (LEAP), conducted in the UK, was published in the *New England Journal of Medicine*. This large, randomised, controlled trial showed that early introduction (between 4 and 11 months) and sustained intake (until age 60 months) of dietary peanut protein can significantly decrease the risk of peanut allergy in children at high risk for this allergy.⁴ The study children had severe eczema, egg allergy or both.

The LEAP trial showed that regular peanut protein consumption was associated with a reduction in peanut allergy at age 5 years by up to 86% in high-risk, non-sensitised infants, and 70% in high-risk, sensitised infants. Peanut avoidance was associated with a higher frequency of clinical allergy than consumption. Approximately 300,000 babies are born each year in Australia. Almost 3% of Australian children have a peanut allergy.⁵ Therefore, 9000 children per year are developing a peanut allergy, but this latest research suggests that in 70–86% of infants this need not happen.

As GPs we see antenatal and postnatal families. We are often asked for advice on infant feeding. For too long it has been the norm to state 'breast is best' and that the World Health Organization and National Health and Medical Research Council recommend exclusive breastfeeding for 6 months. The current Australasian Society for Clinical Immunology and Allergy (ASCI) Infant Feeding Advice (2010), states that 'there is insufficient evidence to support previous advice to specifically

delay or avoid potentially allergenic foods (such as egg, peanuts, wheat, cow's milk and fish) for the prevention of food allergy or eczema', and recommends the introduction of solid food from 4–6 months.⁶ ASCIA intends to update their *Infant Feeding Advice* documents to incorporate findings from a number of recent studies, including the LEAP trial.

It has now become clear that there is strong and compelling evidence that delays in commencing complementary solids, particularly peanuts, conveys significant risk to our patients. Some questions certainly remain, such as the quantity of peanut protein that should be given, and whether ongoing peanut tolerance is dependent on continual inclusion of peanuts in the diet. From a public health perspective, it is imperative that we as GPs are aware of this evidence and consider recommending exposure to peanut protein and probably other potentially allergenic proteins, for the majority of infants, from about 4 months of age.

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Letters to the Editor

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